500 L Street, Suite 500
Anchorage, Alaska 99501

Telephone: (907) 677-3600
Facsimile: (907) 677-3605
www.alaskalaw.pro

SEDOR WENDLANDT EVANS FILIPPI

Attorneys at Law

Clinton M. Campion
Allen F. Clendaniel
William J. Evans
Lea E. Filippi
Carolyn Y. Heyman
John M. Sedor
John C. Wendlandt

September 7, 2018

Jahna Lindemuth
Attorney General - State of Alaska
1031 W. 4th Ave., #200
Anchorage, AK 99501

Re: **Non-Confidential Public Report of Alaska Psychiatric Institute Investigation**

Dear Ms. Lindemuth:

This report documents findings of my investigation into whether safety, retaliation or hostile environment issues exist at the Alaska Psychiatric Hospital ("API"). Through the course of the investigation, it became evident that multiple inter-related problems plague the operation of API and contribute both directly and indirectly to the legitimate perception of an unsafe, retaliatory and hostile work environment.

To fully understand the full universe of problems besetting API, it would require a significantly voluminous report. In the interest of time and the State's resources, I am, instead presenting you with this concise public report. This report will provide you with the direct legal answers to the main questions posed by the State in requesting the investigation. In addition, this report will reference the myriad factors that are contributing to the issues faced by API.

Description of Investigation:

The contract for this work defined the project as confidential "Investigation of possible workplace safety violations and hostile work environment.[1]

[1] Standard Agreement Form, Contract #18-210-1018.

Scope of the Investigation:

The investigation involved interviews of forty-six persons associated with API conducted between March 26 and June 19, 2018.[2] The investigations included both current and former employees of API, Union representatives, DHSS representatives and State of Alaska Human Resources representatives. The positions of the employees interviewed from API spanned a wide range including Psychiatric Nurse Assistants ("PNAs"), Registered Nurses, Psychologists, Psychiatrists, Pharmacists, Occupational Therapists as well as the entire top administration. In addition to the in-person interviews, an extensive number of documents, reports and studies were reviewed regarding the operations at API.

Questions Presented:

1) Does API present an unduly unsafe work environment for its staff?[3]

2) Does the administration of API engage in unlawful retaliation directed against persons who complain about safety issues or who bring safety issues to the attention of management?

3) Does the administration of API create a Hostile Work Environment Directed at persons who complain about safety issues or who bring safety issues to the attention of management?

---

[2] Interviews were conducted at API, other state offices and at my law office depending upon the preference of the interviewee. No persons were required to be interviewed at API.

[3] The question was formulated in this manner to acknowledge the fact that certain inherent dangers exist in the operation of acute care psychiatric hospitals. Accordingly, the real issue is whether the operation of API involves safety issues that could and should be mitigated. For more information concerning the overall safety issues at psychiatric hospitals in general and API in particular see: *Violence and Aggression in an Inpatient Psychiatric Hospital,* Organizational Analysis Project, Gerald Matone RN, MS, March 18, 2015. See also *An Assessment of Levels of Safety in Psychiatric Units*, Sara Bayramzadeh, Health Environments Research & Design Journal, Vol. 10, 2017

Answers:

1) **Does API present an unduly unsafe work environment for its staff?**

Answer: Yes.

The Alaska Department of Labor and Workforce Development, Occupational Safety and Health ("AKOSH") has investigated API and in November 2017 cited it for being unsafe.[4] API was similarly cited by AKOSH in 2014.[5]

As an acute care psychiatric hospital, API has unquestionable inherent and somewhat unavoidable safety issues. All of those involved realize that it is not possible to create a 100% safe acute care psychiatric hospital. There are a number of factors, however, that appear to unnecessarily contribute to the workplace dangers occurring at API. These factors include the following:

a. ***Ineffective Scheduling Practices*** – The nursing administration at API has a very difficult time scheduling PNAs and Nurses in a manner that provides sufficient coverage for all shifts. Because of these scheduling difficulties, some shifts and days will have a bare minimum of coverage while other shifts and days may have excess personnel. This scheduling deficiency makes it difficult to accurately identify the overall personnel needs for the facility. It is possible, however, that if scheduling can be accomplished in an efficient manner, additional staff may prove necessary to ensure a full complement of employees on each unit on each shift each day.[6] An additional component complicating effective scheduling is the cap on overtime that was recently imposed.[7] Often employees will agree to work more desirable assignments early in the

---

[4] See Alaska Department of Labor and Workforce Development, Occupational Safety and Health Inspection number 1244297, issued November 27, 2017.

[5] See AKOSH inspection number 316900703, issued December 23, 2014.

[6] It is not surprising that a large majority of unit staff (PNAs and Nurses) identify a shortage of staff as a significant safety concern. In situations in which emergencies often result in the need to physically control a violent patient, having more employees available to assist provides a greater sense of safety and security.

[7] The cap on overtime hours imposed in 2017 was part of API's Plan of Correction in response to the violations cited by AKOSH.

week and thus be unavailable for overtime on the weekends which causes weekend personnel to feel less safe as they tend to have less personnel available.[8]

b. ***The Use of On-Call personnel*** – While some on-call personnel are acknowledged to be very good employees, a number do not have sufficient experience to be effective working on the units. There is also a perception that on-call workers do not display or possess the same commitment to the institution that full-time permanent workers possess. The use of on-call personnel will often cause the regular staff to feel less safe as they do not feel they can fully count on proper assistance from the on-call personnel in the event of a code or emergency.

c. ***Cultural Divide Concerning the Use of Restraints and Seclusion*** – The largest single issue impacting the overall work environment at API is the significant cultural divide that exists surrounding the issue of patient safety versus staff safety. The personnel involved in Quality Improvement ("QI") are at the forefront of ensuring that the facility complies with Centers for Medicare and Medicaid Services ("CMS") regulations concerning the proper use of restraints and seclusion with respect to patients. Accordingly, QI tends to be the main force behind staff disciplinary actions for engaging in improper use of restraints and seclusions. A large segment of the staff believe that QI and the administration are being overly zealous in protecting patients and thereby reducing the staff's ability to maintain safe control of the units. The divide between patient safety and staff safety is much broader than API. Many mental health professionals believe that a reduced use of restraints and seclusion results in less incidents of injuries to staff.[9] A large section of the staff, however, are not convinced of this somewhat

---

[8] The lack of personnel available on the weekend is also compounded by the lack of Monday through Friday administrative staff available on the weekend. Administrative staff can at times assist and respond to codes.

[9] For further information concerning studies of Restraint and Seclusion see: *A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: patient, staff and ward characteristics*, Husum et al., BMC Health Services Research 2010; *The Distribution and Frequency of Seclusion and/or Restraint among Psychiatric Inpatients*, Hendryx et al., The Journal of Behavioral Health Services & Research, April 2010; *Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends*, Steinert, et al. Social Psychiatry & Psychiatric Epidemiology, 2010; *The Reasons for using restraint and seclusion in psychiatric inpatient care: A nationwide 15-year study*, Valkama, et al. Nordic Journal of Psychiatry, 2010; *Reduction of Restraint and Seclusion Through Collaborative Problem*

counterintuitive theory and believe that not intervening promptly and consistently increases the danger both to staff and to other patients.[10]

Directly related to the cultural divide between the patient safety and staff safety adherents is a widespread lack of confidence in the use of NAPPI ("Non-Abusive Psychological and Physical Intervention").[11] NAPPI is the intervention program selected by API for use in handling patients. Many of staff members believe NAPPI does not provide a realistic ability to safely control a patient who is behaving violently.[12] Accordingly, a significant portion of the staff feel unequipped to properly handle a dangerous patient. This is exacerbated by concern that failure to follow strict NAPPI protocols will result in disciplinary action. This increases the chilling effect whereby a number of staff are simply avoiding, if at all possible, responding to codes and similar situations.[13]

Solving: A Five-Year Prospective Inpatient Study, Martin et al. Psychiatric Services, Vol. 59, 2008; *Organizational and Unit Factors Contributing to Reduction in the Use of Seclusion and Restraint Procedures on an Acute Psychiatric Inpatient Unit*, Pollard, et al. Psychiatric Quarterly, November 2006; *Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review*, Goulet and Larue, Archives of Psychiatric Nursing 30, 2016.

[10] It should be noted that the staff members who argue in favor of a more liberal use of restraints and seclusion are not advocating that patients should be abused. All appear to be committed to the safety and well-being of the patients.

[11] NAPPI was selected as a replacement for the MANDT system which is the other widely used manual restraint system. The switch to NAPPI was believed to be in the interest of improving the safety of both patients and staff.

[12] Like a self-defense technique, NAPPI requires significant practice and experience in order to employ it properly when faced with a highly resistant and unpredictable patient. Often a situation may begin with a staff member attempting to utilize a NAPPI technique, but the situation will devolve into a more basic physical struggle when the staff member is not able to use NAPPI effectively to deal with the changing and often escalating circumstances. Staff members are concerned that when NAPPI is not used or not used properly, they will be disciplined for the failure.

[13] For more information concerning the use of de-escalation approaches see: *Coping with Violence in Mental Health Care Settings: Patients and Staff Member Perspectives on De-escalation Practices*, Berring, Pedersen and Buus, Archives of Psychiatric Nursing 2016.

The fundamental cultural divide existing at API cannot be overstated as it permeates nearly all aspects of the workplace. At present the staff expresses tremendous anxiety about utilizing any force in any situation involving a patient as they are fearful that their interaction will be scrutinized by QI based on video evidence and they will be disciplined or possibly terminated. This hesitancy and uncertainty, in and of itself, contributes to an actual safety concern as hesitation to act promptly could result in the escalation of a situation into a much graver and more violent situation. This also leads to an increased perception of danger because staff members are uncertain as to whether other staff members can be counted on to react in a crisis. The nature of this divide is further evidenced by the recent email messages sent by the Safety Officer to many public figures claiming that a culture of "patient abuse" exists at API and that his calls to address it have gone unheeded.

d. ***Lack of Programming*** – Over several years the programming available to patients at API has reportedly changed.[14] To the extent programming has been reduced it could impact safety in a number of ways. With less programming, patients have greater unstructured time which can result in increased stress and boredom; and in turn can manifest itself in a variety of patient outbursts. A reduction in programming can also diminish the success rate for integrating a patient back into the community. The less prepared the patient is for the transition, the greater the likelihood of a subsequent readmission.[15] It is widely acknowledged that returning patients, especially those who return repeatedly, pose a greater risk of harm to staff and other patients.

---

[14] Some of the reported changes are likely due to the transformation from a larger psychiatric hospital to the current smaller acute care facility which is focused on shorter-term stays; and consequently would be expected to have less long-term programming options. It has been reported anecdotally by some staff that API used to have a greater number of Occupational Therapists, Recreational Therapists and Industrial Therapists that assisted patients in their transition back into the community. According to some staff members, these positions have been declining steadily over the years and therefore fewer opportunities exist for the types of programming offered by this type of personnel. The claimed reductions in these positions have not been independently verified by this investigation.

[15] It has also been suggested that greater emphasis should be placed on cultural issues related to the Alaska Native community and issues faced by patients returning to rural Alaska as a means of reducing re-admission rates for this population.

e. ***PNA Qualifications*** – Psychiatric Nurse Assistants are arguably the most critical positions in the hospital. They spend the most time directly interacting with the patients and are the largest single group of employees at the hospital. The qualifications for becoming a PNA are, however, non-demanding. Essentially, all that is required is a high-school diploma. No training in nursing, first aid or mental health is required in order to be eligible for hire. On-the-job training is provided once they are hired, but a number of employees have advocated for increasing either the qualifications necessary or the post-hiring training for PNAs.

f. ***Lack of Intensive Care/Admitting Unit*** – The facility would benefit from a unit designed to house patients who have been identified as being most likely to create harm. Such a unit, however, must be staffed by employees who have the experience and demonstrated ability to handle the most acute patients in an appropriate manner. This may require consultation and cooperation with the Union to ensure that the proper personnel can be assigned specifically to the acute care unit.[16]

g. ***Patient Population Changes*** – Because of restrictions and limitations existing outside of API, the facility has had to accommodate a growing number of patients who are not mentally ill. For example, individuals with severe developmental disabilities, dementia and autism who demonstrate violent or aggressive behaviors are often banned from, or barred entry into, group and assisted living homes. Such individuals are often sent to API as a placement of last resort. This patient population tends to remain at API for longer periods due to barriers involved in their discharge to the community.[17] This non-mentally ill patient population also tends to consume considerable staff time and resources which places further stress on overall staffing requirements. Notably, many

---

[16] One issue that might have to worked out with the Union would be the impact that Article 27 of the General Government Bargaining Unit CBA governing shift assignments would have on the selection process for personnel staffing an intensive care unit. Article 27 states that "seniority" shall be considered in assigning employees to desired shift.

[17] There are a limited number of community providers available for placement of these individuals. In addition, for certain patients, a guardianship process must be completed prior to the patient being discharged to a community-based service. Because the patients are considered in a safe environment while at API, the guardianship process is not considered an emergency process and as such can take from three to six months to complete.

personnel report anecdotally their perception that overall patient acuity and violence seems to be on the rise, which appears consistent with information nationwide.[18]

The concept of a smaller acute care short-term facility was premised on the understanding that the broader community would have resources for treatment once a patient was stabilized.[19] For a variety of reasons, it does not appear that the community mental health resources has kept pace with the demand for services. This has impacted the nature of the patient population at API, the duration of patient stays, the re-admission rate and ultimately the overall safety of the facility.

h. Lack of Consequences for Assaultive Patients – A significant number of staff members complain that patients who engage in physical assaults on staff receive no punishment, either within the hospital or by law enforcement. Because the hospital attempts to protect its provider/patient relationship with patients it does not assist employees who wish to pursue criminal charges against assaultive patients. This lack of involvement is often interpreted by staff as being unsupportive of them as victims of assault. Staff is also critical of the Anchorage Police Department who are reluctant to arrest a patient at API. This has created a perception among much of the staff that they are viewed as expendable - that patients are allowed to assault them and injure them at will and neither the hospital nor the justice system will take any action.

2) **Does the Administration of API engage in unlawful retaliation directed against persons who complain about safety issues or who bring safety issues to the attention of management?**

---

[18] An overall rise in violent behavior in hospital settings has been broadly noted. See Katherine D. Warburton's book, *Violence in Psychiatry*, 1st Edition, Cambridge University Press, 2016, provides insight into this overall trend.

[19] For an in-depth explanation of the anticipated inter-relationship between API and Community Mental Health Services see: *Alaska Comprehensive & Specialized Evaluation Services,* History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project, University of Alaska, ACSES Technical Report No. 85, June 23, 2003. For a detailed account of the many issues stemming from the "deinstitutionalization" of the mental health system see: *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System*, E. Fuller Torrey, Oxford University Press, 2014.

Answer: Qualified No.

For the purposes of this analysis, the prima facie case for retaliation as set forth in Veco, Inc. v. Rosebrock, 970 P.2d 906, 921 (Alaska 1999) and Kinzel v. Discovery Drilling, Inc., 93 P.3d 427, 433 (Alaska 2004) was used. Accordingly, in order to establish a prima facie case of retaliation, a plaintiff must show: (1) that the employee was engaged in a protected activity; (2) that an adverse employment decision was made; and (3) that there was a causal connection between the two. The investigation did not uncover any evidence of an organized or systematized effort on the part of API administration to retaliate against employees who raise safety concerns. There are, however, certain situations which give rise to a significantly widespread belief among the staff that "retaliation" is prevalent.

The investigation did not uncover any unequivocal instances of retaliation although some situations which are currently in the grievance and arbitration process between API and the Union could reasonably be determined by an arbitrator to constitute retaliation. It does not appear, however, that such conduct, even if deemed retaliatory is part of an on-going or orchestrated retaliatory effort on the part of API administration to silence complaints about safety issues.[20]

a. Video Scrutiny by QI Personnel – A significant driving force in the perception of "retaliation" among the staff at API is the aforementioned cultural divide involving patient and staff safety. Many staff members view video scrutiny engaged in by QI personnel as "retaliation" for outspoken conduct advocating for staff safety. The investigation did not find evidence that the video review and resulting discipline was targeted at individuals advocating for staff safety or complaining of unsafe conditions. Instead, it appears that the underlying divide is based on disagreement concerning the proper interpretation and application of CMS regulations. There is ample evidence that QI personnel are operating under the good faith belief that they are properly enforcing the applicable and necessary regulations and that their actions are in the best interest of API's patients. While their interpretation and application of the regulations may be subject to legitimate challenge, there does not appear to be any credible evidence that their scrutiny

---

[20] As part of the investigation two significant cases that are currently working their way through the Union and API's grievance and arbitration were given extensive and careful review. Because these matters are currently pending in the parties' arbitration process, the details of the review and specific conclusions are not included in this report.

or use of discipline is being levied against employees who complain about safety issues. It is important to understand, however, that even though this "scrutiny" does not appear to rise to the level of unlawful retaliation, it does substantially contribute to a deep level of distrust between the floor staff and second-floor administration.

b. ***Favoritism/Retaliation*** – Many staff broadly use the term "retaliation" when complaining about what is in essence favoritism being shown by the nursing administration. There is a widespread belief by staff that certain employees are "favored" by the nursing administration and are thus granted better treatment and more favorable assignments. Accordingly, those who are "disfavored" are denied promotions, transfers, and other favorable treatment. This disparity in treatment is often referred to by staff as "retaliation" but it would not constitute actionable unlawful retaliation as it is not based on the employee's participation in a protected activity. A number of employees cite this favoritism as being a key reason why a number of employees have left their jobs at API and why a number of those who were interviewed are considering resigning. Of all the issues faced by API the patient safety versus staff safety cultural divide and this issue of nursing administration favoritism seem to have the most significant impact.

c. ***Safety Committee – Relations with Union*** – A change made to the composition of the safety committee has caused some employees and the ASEA Union to claim that the API administration is attempting to silence employees who bring forward complaints about safety. In February 2018, API administration opted to rotate the involvement of the PNA IVs, the most experienced PNAs, in the twice-monthly safety meetings. The Union and some members have expressed concern that API adopted the rotation plan to curtail the voice of the PNA IVs who were regularly participating in the meetings and raising various safety concerns.[21] API administration defends the change by stating that it wanted to incorporate the viewpoints of a broader selection of employees and to open up the Safety Committee process to broader participation. Overall, issues such as this and the general poor working relationship between API administration and

[21] There are certain PNAs who are viewed by API administration as being overly aggressive in their handling of patients. These same PNAs are very involved with the Union and are at the forefront of complaining that staff safety is being sacrificed to patient safety. It is conceivable that API administration adopted the rotation schedule to avoid these PNAs dominating the safety committee discussions. If this was the case, the basis for the decision would not necessarily be an effort to suppress complaints about safety, but rather suppressing a viewpoint about patient interactions with which the administration does not agree.

the ASEA Union contribute to the sense that API administration is not taking safety issues seriously.

d. ***Reverse Retaliation*** – A less common, but still existing form of alleged retaliation involves staff who report patient abuse and who subsequently feel retaliated against by other staff members. These claims often involve psychologists and social work staff who report on misconduct engaged in by PNAs.[22] The retaliation involves minor matters such as failing to acknowledge a person's presence but can involve such safety sensitive issues as refusing to open locked doors for a staff member thus placing them in potential risk of harm.

3) Does the Administration of API create a Hostile Work Environment Directed at persons who complain about safety issues or who bring safety issues to the attention of management?

Answer: No.

For the purpose of this analysis the definition of "hostile work environment" set forth by the Alaska Supreme Court in French v. Jadon, Inc., 911 P.2d 20 (Alaska 1996) was used. This standard sets forth that conduct which unreasonably interferes with work performance can alter a condition of employment and create an abusive working environment. 911 P.2d at 28. Such conduct, however, must be severe or pervasive enough "to create an objectively hostile or abusive work environment" – an environment that a reasonable person would find hostile or abusive. Most importantly for this investigation, actionable "hostile environment" must be discriminatory in nature. In other words, the hostile environment must be due to or connected with membership in a protected class. There was no evidence discovered during the investigation that would support the existence of a hostile work environment targeting employees based on membership in a protected group.[23] There was evidence, however, that under the

---

[22] It is important to understand that the cultural divide concerning patient safety and staff safety is not strictly limited to Quality Improvement opposing floor employees. There are employees who are aligned with the Quality Improvement office in their viewpoint concerning the proper treatment of patients and their views on proper control.

[23] This would include all protected categories found in AS 18.80.220 which includes: race, religion, color or national origin, age, physical or mental disability, sex, marital status, pregnancy or parenthood.

previous "interim" administration, several employees believed that an unlawful hostile environment was created that was targeted at protected categories.[24]

Many employees utilize the term "hostile environment" as a broad brush to describe their frustration with the: (1) scrutiny by the QI staff and the seeming concern for patient safety at the expense of staff safety; (2) favoritism by the nursing administration; and (3) the perception of the lack of sufficient staffing.[25] While these categories of perceived hostile environment negatively impact the workplace, they do not appear to constitute an actionable claim for unlawful hostile environment because the motivation for the hostility is not rooted in membership in a protected category or even in the expression of safety concerns. Accordingly, while a number of employees may honestly view the workplace environment as "hostile," it is not the sort of "hostile work environment" that would constitute unlawful discrimination.

Sincerely,

SEDOR, WENDLANDT, EVANS & FILIPPI, LLC

William J. Evans

---

[24] During the interim administration preceding the current administration several employees raised or initiated hostile work environment complaints based on harassment of protected categories (i.e. sex and race). These complaints did not result in any official findings of harassment or discrimination. The interim administration had many defenders as well who believed that the perceived harassment was reflective of the interim administration being curt in its efforts to reform the institution and not discriminatory in nature.

[25] The phrase "perception of lack of sufficient staffing" is used to connote that the lack of effective scheduling conceals the actual existence or magnitude of a staffing shortage.